

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155772	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/14/2011
NAME OF PROVIDER OR SUPPLIER COBBLESTONE CROSSINGS HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E HOWARD WAYNE DRIVE TERRE HAUTE, IN 47802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00087648.</p> <p>Complaint IN00087648 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date: April 14, 2011</p> <p>Facility number: 011906 Provider number: 155772 AIM number: 200912380</p> <p>Survey team: Diane Dierks, RN</p> <p>Census bed type: SNF: 51 Residential: 33 Total: 84</p> <p>Census payor type: Medicare: 41 Other: 43 Total: 84</p> <p>Sample: 3</p> <p>Cobblestone Crossings Health Campus was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00087648.</p> <p>Quality review completed 4/19/11 by Jennie Bartelt, RN.</p>	R 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

P5VH11

If continuation sheet 1 of 1